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## OPERATION RESTORE TRUST



February 6, 1997

Ms. Theresa Ginnetti, Benefits Integrity Unit  
Aetna Life Insurance, Co.  
25400 US 19 N., Suite 135  
Clearwater, FL 34623-2193

Dear Ms. Ginnetti:

The enclosed report and recommendations for corrective actions provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Colonnade Medical Center (Medicare provider number 10-5480), a skilled nursing facility located in Lauderdale Lakes, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from November 1, 1994 through December 31, 1995.

The ORT reviewers questioned \$385,338 in charges reported for the 30 sample beneficiaries in our study. This amount comprises \$195,247 related to Physical therapy services; \$79,330 in Occupational Therapy services; \$15,780 in Speech Therapy services; and \$37,766 in Respiratory Therapy Services, that were considered not to meet Medicare coverage requirements; \$51,095 in undocumented services; and \$6,120 in inappropriate equipment charges. Therefore, we are recommending an adjustment of the above charges and that the FI conduct a focused review of all rehab therapies since the period of our review in order to recoup overpayments made to this SNF and to implement corrective action by the facility.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendation made in the report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely,

A handwritten signature in cursive script that reads "Patricia L. Talley".

Patricia Talley  
Acting HCFA Regional Administrator

A handwritten signature in cursive script that reads "Charles Curtis".

Charles Curtis  
Regional Inspector General -

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## OPERATION RESTORE TRUST



February 6, 1997

Mr. Marshall Kelley, Director  
Division of Health Quality Assurance  
Agency for Health Care Administration  
2727 Mahan Drive  
Tallahassee, FL 32308

Dear Mr. Kelley:

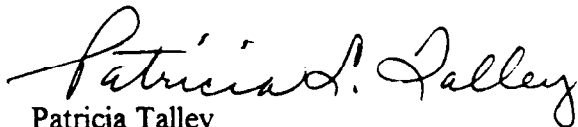
The enclosed report and recommendations for corrective actions provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Colonnade Medical Center (Medicare provider number 10-5480), a skilled nursing facility located in Lauderdale Lakes, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from January 1, 1994 through December 31, 1994.

The ORT reviewers questioned \$385,338 in charges reported for the 30 sample beneficiaries in our study and we are recommending an adjustment of the above charges. In addition, we request that the State Agency implement certain corrective actions by this facility.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations directed to the State Agency made in the report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely,

  
Patricia Talley  
Acting HCFA Regional Administrator

  
Charles Curtis  
Regional Inspector General - Audit

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## I. EXECUTIVE SUMMARY

This report provides the results of our Operation Restore Trust (ORT) survey of Colonnade Medical Center (Colonnade), a skilled nursing facility (SNF) in Lauderdale Lakes, Florida. The objective of the survey was to determine whether charges other than room and board, billed to the Medicare Part A Fiscal Intermediary (Intermediary) and Part B Carrier (Carrier), were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. For these services to be allowable they must be:

- o considered a specific and effective treatment for the patient's condition;
- o prescribed under the assumption that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician;
- o reasonable in amount, frequency, and duration; and
- o fully supported by the patient medical records.

A team comprised of a Florida State Agency for Health Care Administration (State Agency) nurse surveyor, a Regional Health Care Administration (HCFA) nurse consultant, and an Office of Inspector General (OIG) Office of Audit Services auditor conducted an unannounced focused survey at Colonnade. The members of the team evaluated the services for 30 Medicare beneficiaries with aberrant charges made for the period January 1, 1994 through December 31, 1994. This period coincided with the SNF's Medicare fiscal year 1994 (FY 1994).

We found \$385,338 in charges reported by the SNF that did not meet Medicare reimbursement guidelines as stated above for 23 of the 30 beneficiaries in the sample. The disallowed costs consists of \$239,469 of occupational, physical, speech, and respiratory therapy services which were not reasonable or medically necessary, \$88,655 of occupational, physical, speech, and respiratory therapy services which were undocumented, \$51,095 of charges for 1 beneficiary whose records were not located by the SNF and \$6,120 of charges for equipment inappropriately billed.

The therapy overcharges of \$239,469 occurred because the SNF prescribed therapy services to all its residents upon admission and re-admission without specific medical indications for such services. We are recommending that the Intermediary make an adjustment of \$385,338 from the charges reported by the SNF on its FY 1994 cost report, identify and recoup overpayments for subsequent periods, and for the State Agency to require certain corrective actions by the facility.

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## REGION IV OPERATION RESTORE TRUST PILOT

### FOCUSED REVIEW OF A SKILLED NURSING FACILITY

#### II. BACKGROUND

The Secretary of the Department of Health and Human Services and the President initiated Project ORT. This innovative, collaborative project was designed to address growing concerns over rising health care costs. A review of departmental records indicated that over the last 10 years, the following segments of the health care industry have experienced a surge in health care fraud:

- o home health,
- o nursing homes,
- o hospice, and
- o durable medical equipment.

Departmental records further disclosed that the States of Texas, California, Illinois, New York, and Florida receive annually over 40 percent of all Medicare and Medicaid funds paid to the above health care segments. As a result, these States and the above health care segments were chosen as targets of the ORT 23-month pilot project.

Within the Department of Health and Human Services, ORT has been a joint effort by HCFA, the OIG, and the Administration on Aging. These components are focusing attention on Program vulnerabilities identified through investigations and audits.

HCFA's Bureau of Data Management Services (BDMS) has identified certain SNFs in Florida as aberrant according to their billings. The method used to identify these providers was to evaluate the universe of SNF admissions in each state during CY 1994. Data for all SNF claims was summarized first by beneficiary, and then by SNF. Key statistical data included total claims per beneficiary, allowed dollars per stay, line items or services per number of beneficiaries, average dollars and claims per stay, and average dollars per day. BDMS generated a listing of SNFs with high reimbursement amounts per day and per stay. The listing of SNFs was manually scanned and 14 were judgmentally selected based on total highest reimbursement.

In addition to these 14 SNFs, we requested the two principal fiscal intermediaries in Florida (AETNA and Blue Cross) to each identify 3 SNFs for inclusion in this project based upon their data, complaints, and experience with SNF providers. Colonnade Medical Center was one of the 14 SNFs judgmentally selected for review. It was selected for the survey based upon its high therapy costs, high average length of stay by the residents, high cost per stay, and high cost per day.

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### III. SCOPE OF REVIEW

The survey was conducted by a team comprised of a nurse surveyor from the State Agency, a nurse consultant from HCFA, and an auditor from the OIG Office of Audit Services. This HCFA directed survey was conducted using HCFA's review protocols rather than the OIG's policies and procedures. Accordingly, the OIG's work was in compliance with generally accepted government auditing standards only in relation to the quantification of the unallowable services identified by other members of the team.

The objective of the survey was to determine whether charges other than room and board, billed to the Intermediary and Carrier, were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. Primarily, we wanted to determine whether unnecessary care was provided to the 30 beneficiaries in our sample, for whom Colonnade billed Medicare \$922,748 during the period January 1, 1994 through December 31, 1994, the facility's Medicare fiscal period.

The approach used was to identify all services billed to Medicare Part A, Medicare Part B, and Medicaid cross-over claims for each of the 30 beneficiaries in our sample during their stay at Colonnade between January 1994 and December 1994. This approach was adopted because many providers, other than Colonnade bill separately for services to the SNF patients, e.g., podiatrists, portable x-ray suppliers, therapy providers and DME suppliers. These claims go to various Medicare contractors and to Medicaid, and are rarely, if ever associated with each other or the SNF's bills.

Using the team concept, the State Agency and HCFA nurses identified Medicare funded services which were either not reasonable or necessary, and the OIG auditor quantified the charges associated with the services. The beneficiaries' medical records and related documentation were reviewed to determine the medical necessity of charged services; specifically, we determined if services were: (i) recorded in the medical records, (ii) ordered by a physician, (iii) rendered by qualified personnel, and (iv) appropriate considering the physicians' diagnosis and the residents' physical/mental condition. The SNF's accounting records and supporting documentation were reviewed to determine: (i) the bases for charges reported to Medicare, and (ii) the amount of charges associated with questioned services.

Field work was performed at the SNF's offices in Lauderdale Lakes, Florida during the period September 3 through September 6, 1996.

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#### IV. FINDINGS AND RECOMMENDATIONS

The review of the 30 beneficiaries included in our survey consisted of a retrospective analysis of their payment history for rehabilitative services under Part A and services provided under Part B while residents of the facility. It is questionable if these beneficiaries met the criteria for rehabilitative services. Our evaluation of the medical records for the 30 beneficiaries resulted in disallowance of \$385,338 in charges reported by Colonnade in its FY 1994 Medicare Cost Report. The disallowed costs consists of \$239,469 of occupational, physical, speech, and respiratory therapy services which were not reasonable or medically necessary, \$88,655 of occupational, physical, speech, and respiratory therapy services which were undocumented, \$51,095 of charges for 1 beneficiary whose records were not located by the SNF and \$6,120 of charges for equipment inappropriately billed. We are recommending that the Intermediary adjust the questioned charges and conduct focused reviews of therapy services reported by the SNF.

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##### QUESTIONED CHARGES

	<u>Billed</u>	<u>Questioned</u>	<u>Percentage</u>
THERAPIES:			
Occupational	\$174,930	\$ 79,330	45%
Physical	494,407	195,247	39%
Speech	41,270	15,780	38%
Respiratory	<u>154,926</u>	<u>37,766</u>	24%
Subtotal	\$865,533	\$328,123	28%
No Medical-Record	\$ 51,095	\$ 51,095	100%
Equipment	<u>6,120</u>	<u>6,120</u>	
Total	\$922,748	\$385,338	42%

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##### OCCUPATIONAL, PHYSICAL, SPEECH AND RESPIRATORY THERAPY SERVICES

We questioned \$328,123 of occupational (OT), physical (PT), speech (ST) and respiratory therapy (RT) services provided to 22 of the 30 aberrant beneficiaries included in our sample. Under paragraph 1861(h)(3) of the Social Security Act, these services are covered under Medicare Part A when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist. The Medicare Intermediary Manual at paragraph 3132 (MIM 3132) states that the ordered therapies provided in a SNF must be reasonable and necessary for the treatment of the beneficiary's

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illness or injury. The questioned charges did not meet the reimbursement criteria.

## **FINDING #1**

### **Occupational Therapy Services**

We questioned \$79,330 of OT provided to 19 of 30 beneficiaries. This cost includes \$47,690 which was not medically necessary and \$31,640 which was not documented. In order to be covered under Medicare Part A such services must be prescribed by a physician, be performed by a qualified therapist, and be reasonable and necessary for the treatment of the individual's illness or injury. OT designed to improve function is considered reasonable and necessary only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning with a reasonable period of time. We do not believe a basis existed for an expectation that the OT services provided would significantly improve the four residents' level of functioning. The following information provides the bases for this conclusion.

- o Therapy goal was to increase endurance and strengthen muscles. The resident's disease and medication prevented the attainment of this goal.
- o Therapy not medically necessary due to cognitive deficits and non-compliance of the resident.
- o Therapy duplicated administered PT and it could have been accomplished by the facility's nursing staff.
- o Therapy was not medically necessary due to decline in resident's medical conditions and cognitive status.

The therapeutic services provided the above residents should have been accomplished by the facility's nursing staff.

## **RECOMMENDATIONS**

We recommend that the Intermediary should:

- Adjust the \$79,330 from OT charges reported by SNF on its FY 1994 cost report.
- Conduct a focused review of all OT services provided at Colonnade for the period of our sample.



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We recommend that the State Agency should:

- Ensure via a Corrective Action Plan (CAP) that OT services are properly ordered, documented, and appropriately provided to patients with specific medical indications for such services.

## **FINDING # 2**

### **Physical Therapy Services**

We questioned \$195,247 of PT provided to 16 of 30 beneficiaries. This cost includes \$141,067 which was not medically necessary and \$54,180 which was not documented. In order to be covered under Medicare Part A, PT services must relate directly and specifically to an active written treatment regimen established by the physician or by the physical therapist providing the services and must be reasonable and necessary to the treatment of the individual's illness or injury (MIM 3101.8). To be considered reasonable and necessary the following conditions must be met:

- o The services must be considered a specific and effective treatment for the patient's condition.
- o There must be an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician.
- o The amount, frequency, and duration of the services must be reasonable.

The following information provides the bases for our questioning the PT services.

- o Therapy was continued after resident was discharged to restorative nursing care.
- o Therapy was continued after resident's cognitive status became very limited. The medical records show she became non-verbal and non-self initiating in daily living skills.
- o The side effect of medication being taken by one resident included muscle weakness, loss of muscle mass and osteoporosis. The PT evaluation did not indicate that the therapists were aware of the resident's bone cancer, his use of steroid drugs, and the side effects of the drugs.
- o Therapy primarily consisted of bandage wraps and measurements.
- o Therapy was continued after resident attained established goals.

**The routine therapeutic services provided the above residents should have been accomplished by the**

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facility's nursing staff.

## **RECOMMENDATIONS**

We recommend that the Intermediary should:

- Adjust the \$195,247 from PT charges reported by SNF on its FY 1994 cost report.
- Conduct a focused review of all PT services provided at Colonnade for the period of our sample.

We recommend that the State Agency should:

- Ensure via a Corrective Action Plan (CAP) that PT services are properly ordered, documented, and appropriately provided to patients with specific medical needs for these services.

## **FINDING #3**

### **Speech Therapy Services**

We questioned \$15,780 of ST provided to 8 of 30 beneficiaries. This cost includes \$15,585 which was not medically necessary and \$195 which was not documented. Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities. They must be related directly and specifically to a written treatment regimen established by the physician (or speech pathologist providing the services). The services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary the following conditions must be met:

- o The services must be considered a specific and effective treatment for the patient's condition.
- o The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist.
- o There must be an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician.
- o The amount, frequency, and duration of the services must be reasonable.

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Our review of the residents' records showed the ST services were not medically necessary. Additionally, the provision of services to one of the two residents was not documented in the records.

## **RECOMMENDATIONS**

We recommend that the Intermediary should:

- Adjust the \$15,780 from ST charges reported by SNF on its FY 1994 cost report.
- Conduct a focused review of all ST services provided at Colonnade since the period of our review.

We recommend that the State Agency should:

- Ensure via a Corrective Action Plan (CAP) that ST services are properly ordered, documented, and appropriately provided to patients with specific medical needs for these services.

## **FINDING #4**

### **Respiratory Therapy Services**

We questioned \$37,766 of RT provided to 5 of 30 beneficiaries. This cost includes \$35,126 which was not medically necessary and \$2,640 which was not documented. These services are reimbursable under Medicare Part A if furnished by a transfer hospital or by a nurse on the staff of the skilled nursing facility. The services are considered medically necessary and reasonable if they meet the following criteria.

- o Consistent with the nature and severity of the individuals's complaints and diagnosis,
- o Reasonable in terms of modality, amount, frequency, and duration of the treatments, and
- o Generally accepted by the professional community as being safe and effective treatment for the purpose used.

Our review of the residents' records showed the documented RT services could have been provided by the facility's nursing staff. Additionally, the provision of services to one of the three residents was not documented in the records.

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## **RECOMMENDATIONS**

We recommend that the Fiscal Intermediary should:

- Adjust the \$37,766 of charges related to those RT services reported by Colonnade on its FY 1994 cost report.
- Conduct a focused review of all RT services provided at Colonnade since the period of our review.

We recommend that the State Agency should:

- Ensure via a Corrective Action Plan (CAP) that RT services are properly ordered, documented, and appropriately provided to patients with specific medical needs for these services.

## **FINDING #5**

### **No Medical Records**

We questioned \$51,095 of services charged for 1 beneficiary for whom the SNF was unable to locate the records.

## **RECOMMENDATION**

We recommend that the Intermediary adjust the \$51,095 from equipment charges reported to the SNF on its FY 1994 cost report.

## **FINDING #6**

### **Equipment**

We questioned \$6,120 of equipment charged to 1 of the 30 beneficiaries included in our sample. Federal regulations at 42 CFR 409.25 state that supplies, appliances, and equipment are covered as extended care services only if they are ordinarily furnished by the skilled nursing facility for the care and treatment of inpatients. The questioned charge was for a surgical bed. We considered that this

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item **should** have been included in the room and board charge.

**RECOMMENDATION**

We **recommend** that the Intermediary adjust the \$6,120 from equipment charges reported to the SNF on its FY 1994 cost report.